Indiana State Department of Health
An Equal Opportunity Employer

Application for a New Intermediate Care Facility for Individuals with Disabilities (ICF-ID) Group Home

An application should include the following forms/documents:

1. Application for License to Operate a Community Residential Facility (State Form 47952)
2. Assurance of Compliance (Form HHS-690) (2 copies)
3. Copy of the letter from the Division of Disability & Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities (BDDS) approving the development of the new home. DDRS/BBDS can be reached at 317/232-1147.
4. Intermediate Care facility for Persons with mental Retardation Survey Report (from HCFA-3079G).
5. Copy of the facility license
6. Articles of Incorporation of the ownership entity
7. Documentation of Registration with the Indiana Secretary of State
8. Floor plan for the new home, to indicate resident bedroom dimensions and square footage, and if the home is sprinklered and has smoke detectors
9. Letter indicating the date the home will be ready for the Life Safety Code Inspection
10. Letter indicating the date the home will be ready for the Health Survey

Please submit the required forms and documentation to the Program Director – Provider Services, Indiana State Department of Health, Division of Long Term Care, 2 N. Meridian Ste. 4-B, Indianapolis, IN 46204.

In the event that the facility will not be ready for the LSC inspection on the date originally specified, you must immediately notify Provider Services in writing. The notification can be mailed to the above address or faxed to 317/233-7322. Failure to communicate requested changes in scheduling could result in delays in opening the home.

After you have moved at least two residents into the home, you may submit a written request for your health survey.

If you have any questions, please contact Provider Services at 317/233-7794 or 317/233-7613.

Websites

Indiana State Department of Health (ISDH)
http://www.in.gov/isdh/20508.htm

Division of Disability & Rehabilitative Services (DDRS)/Bureau of Developmental Disabilities (BDDS)
http://www.in.gov/fssa/ddrs/2639.htm

APPLICATION FOR APPROVAL TO OPERATE A COMMUNITY RESIDENTIAL FACILITY

(Pursuant to Community Residential Facilities Council)

State Form 47952 (R3/12-05)

Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____

Date Approved_____

Approved by_____

Please Print or Type

SECTION I - IDENTIFYING INFORMATION

Name of applicant *(operator(s) of the facility/home)*			
Street Address			P.O. Box
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*
Name of Executive Director			

SECTON II – TYPE OF ENTITY

For Profit	**Nonprofit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION III – RESIDENTIAL FACILITY INFORMATION

A. Address

Street Address		City
County	Zip Code +4	Telephone Number ( )

B. Administrator

Name of Administrator
Qualifications

C. Program Director

Name of Program Director

Qualifications

SECTION IV – TYPE OF PROGRAM (i.e., Licensure Category) AND CAPACITY

TYPE:	CAPACITY:

SECTION VI – TYPE OF APPLICATION

Building Type: ☐ House ☐ Apartment

☐ Proposed New Construction

☐ Alteration of Existing House

☐ Other *(Please Explain):*_____

Does applicant own house? ☐ Yes ☐ No

Is applicant buying house? ☐ Yes ☐ No

Is applicant leasing house? ☐ Yes ☐ No

Note: If house is being leased, submit copy of lease.

SECTION VI – COMPLIANCE WITH RULES

Have you read, and do you understand, the Community Residential Facilities Council Rules? ☐ Yes ☐ No
(431 IAC 1.1, 431 IAC 3.1 and 431 IAC 4)

Will you comply with all laws and rules of the Community Residential Facilities Council as they pertain to the operation of licensed residential facilities for the developmentally disabled? ☐ Yes ☐ No

Does this home agree not to discriminate based on race, color creed, or national origin as provided for in operational policies? ☐ Yes ☐ No

SECTION VII – CERTIFICATION OF APPLICATION

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge, and that I will comply with all laws and rules governing the licensing of residential facilities for the developmentally disabled in Indiana.

Name of authorized representative *(typed)*	Title
Signature	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No. W1

9. State/Region code W2	10. State/County code W3	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below) W6

☐ 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other *(specify)* _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	
O. Total number of QMRP Surveyors onsite	W12	

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☐ Yes ☐ No W13

If *"No"*, proceed to item C.

B. If *"Yes,"* indicate name and address of larger organization.

Name

Address

City | State | ZIP Code

Name of CEO

Total Number of Beds	W14
Total Number of Clients *(including ICF/MR clients directly served)*	W15
C. Total Number of ICF/MR Clients	W16
D. Is this ICF/MR community-based? *(check one)* ☐ Yes ☐ No	W17
E. Total number of ICF/MR beds under this Provider No.	W18
F. Total number of discrete living units under this Provider No.	W19
G. Age range of clients served *from*	W20 *to* W21
H. Total number of off-campus day program sites used by ICF/MR clients	W22

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel W23
(483.430(d)(3)) .....

B. Registered Nurse W24
(483.480(d)(3)) .....

C. Licensed Voc./Practical Nurse W25
(483.480(d)(2)) .....

D. Total Personnel (W26) .....
(List the Full Time Equivalent for all employees)

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs? W27

B. In how many off-campus day program sites was an observation done by the Surveyor? W28

20. Individual Characteristics *(Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)*

A.

(1) Age

under 22(a) W29

22-45 (b) W30

46-65 (c) W31

66+ (d) W32

[redacted] Total W33

(2) SEX

Male W34

Female W35

[redacted] Total W36

B. DISABILITIES

(1) Mental Retardation

Mild W37

Moderate W38

Severe W39

Profound W40

[redacted] Total W41

(2) Autism W42

(3) Cerebral Palsy W43

(4) Epilepsy

Controlled W44

Uncontrolled W45

[redacted] Total W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile W47

Non-Mobile W48

[redacted] Total W49

(2) Speech/Language Impairment W50

(3) Hearing Impairment

Hard of Hearing W51

Deaf W52

[redacted] Total W53

(4) Visual Impairment

Impaired W54

Blind W55

[redacted] Total W56

D. MEDICAL CARE PLAN W57

E. DRUGS TO CONTROL BEHAVIOR W58

F. PHYSICAL RESTRAINTS W59

G. TIME-OUT ROOMS W60

H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI W61

I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS W62

J. NUMBER OF COURT ORDERED ADMISSIONS W63

K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT W64

L. OTHER *(specify)*

(1) W65

(2) W66

(3) W67

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION
SURVEY REPORT

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	W68
no. of allegations of neglect investigated (b)	W69
[redacted] Total	W70

N. NUMBER OF DEATHS

no. of deaths related to unusual incidents (a)	W71
no. of deaths related to restraints (b)	W72
no. of deaths for any reason (c)	W73
[redacted] Total	W74